Chapter 2. Social contexts and relations shaping health workers

Asha George, Ligia Paina, Kerry Scott & Seye Abimbola
Outline

1. Defining HRH social contexts and relations
2. Background on HRH social context and relations
3. Illustrative primary research articles
   - Violence as a structural and gendered driver of inequality
   - Labor markets: economic livelihoods and dynamics
   - Social drivers of migration and retention
4. Research challenges, gaps and future directions
Opening principle

- Health workers are not just conduits for technical skills, they are also human beings and social agents.
- Human agency and social context are key parts of people-centred health policy and systems research (Sheikh et al. 2014).
Definition

• What are key social contexts and social forces or relations that influence health worker behaviour?
Definition

• Social forces are multiple, interactive, dynamic and contextual
• They can foster equity and solidarity or conversely constrain livelihoods and well being
• In this chapter we illustratively review:
  – Humanitarian crisis
  – Gendered violence as a part of gender discrimination
  – Livelihoods and labor market forces
  – Internal and international migration
Background

Humanitarian crisis

• Conflict, natural disasters or unanticipated disease outbreaks are increasing
• Problems of donor coordination & weakened government capacity
• Trust in health providers undermined if seen as aligned with an oppressive government
• In some contexts
  – Substantial informal private provision
  – Windows of opportunity to start new cadres or radical policy departures (evidence still pending)
Background

Gender discrimination & violence

• Health workforce largely feminized, particularly at lower levels, substantial discrimination exists though poorly acknowledged or measured (George, 2007; Newman, 2014)

• Women are systematically paid less even in the same cadre (Tijdens et al., 2013; Vecchio et al., 2013)

• While female physicians work fewer hours than their male counterparts, confounding variables related to physician age, family responsibilities, practice characteristics and patient profile are often not examined sufficiently (Hedden et al., 2014)

• Women more likely to be victimised and suffer more harm due to violence as they internalise blame & lack processes of acknowledgement & redress (Di Martino 2003, Chaudhuri, 2010; George 2007)
Background

Livelihoods: micro-level effects

• Vocation and professional norms are critical social motivations and norms guiding health workers, but so is remuneration and secure livelihoods (McCoy et al. 2008; Tijdens et al. 2013, Bertone and Witter 2015)

• Pay and financial incentives influence
  – Recruitment and retention in public and private sectors
  – Job satisfaction and motivation linking to responsive care
  – Low and unpredictable payment can be used to justify moonlighting and informal fees
Background
Livelihoods: macro-level effects

• Aggregate health worker pay can dominate government health expenditure, particularly in LMICs with low government spending.

• Globally HRH represents on average 34% of total health expenditure. This is set to increase over time, and is rising faster than in other sectors (Hernandez-Peña et al. 2013).

• Wage ranking is relatively consistent at the extremes of the spectrum, typically with doctors at the top and care workers at the bottom (Tijdens et al., 2013).

• Wage ranking of nurses and midwives varies considerably by health system, as does the wage disparity between health cadres (Tijdens et al., 2013).
Background: Complexity of structural basis of health work

In western Europe,

• there is an overall shortage of health workers and increasing future demand
• yet many basic- to middle-level health workers have flexible contracts, work part time or are looking to leave the sector
• working conditions for those at lower levels are not improving
• heterogeneity of these changes across cadres and countries eludes neat categorization by health workforce theories aligned with the professions, the welfare state or labour markets

(Pavolini and Kuhlmann, 2016)
Background: Labour market forces

• A health labour market is a dynamic system comprising two distinct but closely related economic forces: the supply of health workers and the demand for such workers, whose actions are shaped by a country's institutions and regulations (McPake et al. 2013)

• Social institutions structure economic exchanges (Ostrom 2010) through formal rules (regulations, policies and guidelines) and informal rules (social norms, unwritten codes of conduct, and shared strategies)

• Labour markets are shaped by both top-down and bottom-up social forces (Abimbola et al. 2014)
Background
Migration & retention

• Key questions:
  – why and how health workers move,
  – whether and how this movement affects health systems and health outcomes, and
  – how to manage the push and pull factors for health workers (Kroezen et al., 2015; Labonte et al., 2015)

• Two important and related dimensions
  – Internal migration and retention
  – International migration
Background
Migration & retention

• Framework for conceptualizing internal migration and for evaluating interventions that aim to increase access to health workers in underserved communities (Huicho et al. 201)

• Cost-effectiveness of policy measures to retain workers in rural areas (Keuffel et al. 2016; Lagarde et al. 2012)

• WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010)

• Research on early implementation of the Code (Tankwanchi et al. 2014; WHO 2016)
Multidisciplinarity a key aspect of HPSR

- Descriptive: To describe to enable comparability with other contexts and experiences
- Exploratory: Initial research to understand and build hypotheses, concepts, theories
- Explanatory: In-depth research using and testing theory to explain causal mechanisms
- Predictive: To inform about the consequences of preferences and decisions
- Emancipatory: To jointly understand a problem, act on it, and learn from working collaboratively and address power
- Influence: To assess the impact of one variable on another (adequacy, plausibility and probability analysis)

What, when where?

How and why?

What if? What next?

How to empower with change?

What works to effect change?

HPSR Reader on HRH
3. Illustrative primary research articles

• Violence as a structural and gendered driver of inequality
  – Life histories in post-conflict Uganda (Namakula et al. 2014);
  – Gender and violence in the workplace in Rwanda (Newman et al.)

• Labor markets: economic livelihoods and dynamics
  – Livelihoods of volunteer caregivers in Ethiopia (Maes et al. 2011)
  – Income sources of primary health care workers in DRC (Maini et al. 2017)
  – Determinants of dual practice (McPake et al. 2014)
  – Labour market dynamics in Vietnam (Vujicic et al. 2011)

• Social drivers of migration and retention
  – Factors underpinning outmigration from Ireland (Humphries et al. 2015)
  – Factors underpinning retention in rural Mali (Hurley et al. 2014)
3. Illustrative primary research articles

Violence as a structural and gendered driver of inequality


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<tr>
<th>Cadres</th>
<th>Community workers</th>
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<tr>
<td>Geographical Area</td>
<td>Uganda</td>
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<tr>
<td>Research Methods</td>
<td>Qualitative: Life histories</td>
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<td>Research Inference</td>
<td>Exploratory/ Emancipatory</td>
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Living through conflict and post-conflict: experiences of health workers in northern Uganda and lessons for people-centred health systems

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Providing people-centred health systems—or any systems at all—requires specific measures to protect and retain healthcare workers during and after the conflict. This is particularly important when health staff are themselves the target of violence and abduction, as is often the case. This article presents the perspective of health workers who lived through conflict in four districts of northern Uganda—Gulu, Lira, Amuru, and Kitgum. These contained more than 90% of the people displaced by the decades of conflict, which ended in 2006. The article is based on 26 in-depth interviews, using a life history approach. This participatory tool encouraged participants to record key events and decisions in their lives, and to explore areas such as their decision to become a health worker, their employment history, and their experiences of conflict and coping strategies. These were analyzed thematically to develop an understanding of how to protect and retain staff in these challenging contexts. During the conflict, many health workers lost their lives or witnessed the death of their friends and colleagues. They also experienced abduction, ambush and

One of the first uses of life history method in HPSR

• Promising method to conduct a holistic analysis of health worker lives

• Documenting personal and contextual factors while facilitating reflection on important experiences, in a sensitive, participant-led manner.

Successfully identified policy levers for health workforce retention in post-conflict settings
3. Illustrative primary research articles

Violence as a structural and gendered driver of inequality


<table>
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<tr>
<th>Cadres</th>
<th>Multiple public and private sector facility health workers</th>
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<tr>
<td>Geographical Area</td>
<td>Rwanda</td>
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<tr>
<td>Research Methods</td>
<td>Mixed: provider survey, facility audits, key informant interviews, in-depth interviews, focus group discussions, stakeholder engagement</td>
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<td>Research Inference</td>
<td>Descriptive</td>
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What makes it exemplary?

Uses a range of methods to explore link between workplace violence and gender

- First: qualitative formative research for culturally appropriate descriptions of violence and gender discrimination
- Second: surveys, interviews, facility audits to measure and understand

Theory-driven consultation and research dissemination process

- Engaged government and civil society
- Identified information most valuable to inform decisions and improve conditions for health workers
3. Illustrative primary research articles

**Labor markets: economic livelihoods and dynamics**


_Health Policy Plan. 26(1):43–52_

<table>
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<tr>
<th>Cadres</th>
<th>Volunteer caregivers</th>
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<tr>
<td>Geographical Area</td>
<td>Ethiopia</td>
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<tr>
<td>Research Methods</td>
<td>Mixed: provider survey with ethnographic observation over 20 months, in-depth interviews, focus group</td>
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<tr>
<td>Research Inference</td>
<td>Exploratory</td>
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What makes it exemplary?

Innovative mixed-methods:
- Combines longitudinal ethnography and cross-sectional survey methods
- Re-interviewed carers up to 7 times
- Survey to gather demographic data
- Validated scale to measure food insecurity

Focuses on often undervalued and overlooked cadre
Explores how structural forces affect the capacity and livelihoods of volunteers and the sustainability of health programmes
3. Illustrative primary research articles

**Labor markets: Economic livelihoods and dynamics**


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<tr>
<th>Cadres</th>
<th>Public sector primary health care workers</th>
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<tr>
<td>Geographical Area</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>Research Methods</td>
<td>Mixed: facility and provider survey, qualitative interviews</td>
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<td>Research Inference</td>
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HPSR Reader on HRH
What makes it exemplary?

- Few empirical studies obtain data on both the formal and informal sources of income among health workers, particularly in LMICs.

- Used mixed-methods to explore how adaptations in local health care markets, in the form of informal sources of remuneration, partially fills the space left by the lack of institutions to ensure the reliable provision of public goods.

- Highlights the role of gender (male) in determining level (higher) and source (informal) of income.
3. Illustrative primary research articles

Labor markets: Economic livelihoods and dynamics


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<th>Cadres</th>
<th>Physicians</th>
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<tr>
<td>Geographical Area</td>
<td>Mozambique, Guinea-Bissau, Cabo Verde (sub-Saharan Africa)</td>
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<tr>
<td>Research Methods</td>
<td>Two-stage estimation model with propensity score-matching based on provider surveys</td>
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<td>Research Inference</td>
<td>Explanatory</td>
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What makes it exemplary?

- Few empirical studies on dual practice because provider time allocation between public and private sectors, as well as remuneration are unobservable, particularly in LMICs

- Multi-country study; used propensity score matching to objectively estimate remuneration in private sector to understand determinants of dual practice and predictors of how doctors choose to allocate time between public and private spaces
3. Illustrative primary research articles

**Social drivers of migration and retention**

*Humphries N, et al. (2015). “Emigration is a matter of self-preservation. The working conditions ... are killing us slowly”: qualitative insights into health professional emigration from Ireland. Hum Resour Health. 13(1):35*

<table>
<thead>
<tr>
<th>Cadres</th>
<th>Physicians, nurses, midwives</th>
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<tr>
<td>Geographical Area</td>
<td>Ireland</td>
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<tr>
<td>Research Methods</td>
<td>Online survey eliciting social media free-text responses</td>
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<td>Research Inference</td>
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What makes it exemplary?

- Key barriers to migration research are fragmented and incomplete data, as well as lack of reliable sampling frames.
- Use of social media as a data collection platform to collect the perspectives of emigrant health professionals from Ireland.
- Unique focus on factors that would influence return to source country.
3. Illustrative primary research articles

**Labor markets: Economic livelihoods and dynamics**


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<th>Cadres</th>
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<tr>
<td>Geographical Area</td>
<td>Vietnam</td>
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<tr>
<td>Research Methods</td>
<td>Quantitative: discrete choice experiments based on a labour market survey</td>
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<td>Research Inference</td>
<td>Descriptive</td>
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What makes it exemplary?

- Used an innovative combination of quantitative methods – discrete choice experiments and labour market survey – to estimate health worker preferences, income levels, and movements in response to earning potential.

- Demonstrates counterintuitive “market” behaviour: despite the opportunity for increased earnings very few physicians move to urban areas or to higher-level facilities from rural primary health care facilities.
3. Illustrative primary research articles

Social drivers of migration and retention


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<th>Cadres</th>
<th>Rural auxiliary midwives</th>
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<tr>
<td>Geographical Area</td>
<td>Mali</td>
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<tr>
<td>Research Methods</td>
<td>Mixed: semi-structured interviews and social network case studies with midwives and village women</td>
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<td>Research Inference</td>
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</table>
What makes it exemplary?

- One of the few studies using social network theory and analysis to better understand health workforce behaviour – existing network studies in health often focus on physicians or nurses in high-income settings.

- Uses qualitative (semi-structured interviews) and quantitative (social network analyses) methods to obtain a rich picture of context (e.g. social capital, social fabric, connectedness, and belonging to a community) that influence migration and rural retention.
4. Research challenges, gaps and future directions

• **Better data and further research** to better document social context & relations
  – gender,
  – labor markets
  – humanitarian crises settings, sub-national settings, cross-national comparisons

• **Further depth**
  – Move beyond purely descriptive, to theory-informed multi-disciplinary understanding
  – More work on how social forces interact with one another and how they uniquely manifest themselves in various contexts (intersectionality)

• **Further innovation** – to overcome gaps in data and methodology
  – ways of producing and accessing information on migration (e.g. social media, digital technologies)
  – ways of contesting power relations within research to ensure health worker voice & agency through the principles of participatory action research
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http://www.who.int/alliance-hpsr/resources/publications/9789241513357/en/